PELVIC/PAP EVALUATION

Today's Date ______________________________

Name ___________________________________ Weight _________ Temp _________ B/P ________

HEENT

CHEST

HEART

BREAST

ABDOMEN

PELVIC BUSV

CERVIX

UTERUS

ADNEXAL

RECTAL

MENSTRUAL HISTORY

L.M.P. ___________________________________

P.M.P. ___________________________________

DURATION OF MENSES

SPOTTING/DISCHARGE

MENOPAUSE	❑ YES	❑ NO
HYSTERECTOMY	❑ YES	❑ NO
OOPHORECTOMY	❑ YES	❑ NO

1. GYNECOLOGY-PROBLEMS / SYMPTOMS

2. CURRENT Rx PLAN